Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov
MEDICAID MEMO

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Enhanced Ambulatory Patient Group (EAPG) for Outpatient Hospital Services

The purpose of this memo is to inform you of a new reimbursement methodology for outpatient hospital services, effective January 1, 2014. In a Medicaid Memo dated April 6, 2011, DMAS notified providers of the proposed change in reimbursement and described the outpatient hospital coding requirements. Currently, Medicaid reimburses all outpatient hospital services, excluding laboratory services and non-emergencies, a percentage of costs. Laboratory services are reimbursed at the state agency fee schedule. Non-emergencies are reimbursed at a rate of $30.

Effective for claims with dates of service on or after January 1, 2014, DMAS will reimburse outpatient hospital services using a new Enhanced Ambulatory Patient Group (EAPG) methodology developed and licensed by 3M. The EAPG methodology defines Enhanced Ambulatory Patient Groups (EAPGs) as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed in an outpatient hospital setting. Each EAPG group shall be assigned an EAPG relative weight that reflects the relative average cost for each EAPG compared to the relative cost for all other EAPGs.

Assignment of EAPGs is based primarily on procedure codes, which are not used under the current reimbursement methodology. Correct procedure coding has been required since June 1, 2011 and is critical to appropriate reimbursement under the new reimbursement methodology. Some EAPGs also utilize the primary diagnosis for assignment. The EAPG software also determines a payment action based on the clinical logic included in the software. The software assigns a payment percentage to each EAPG assigned on the outpatient hospital claim based on the payment action determined. Outpatient hospital services reimbursed through EAPG will be subject to National Correct Coding Initiative (NCCI) edits. To maintain DMAS ability to claim drug rebates, each drug administered in the outpatient hospital setting shall be reimbursed separately if the claim line has an appropriate procedure code.

For private, Type Two, hospitals, a statewide base rate for outpatient hospital visits shall be calculated using base year cost data inflated to a rate year adjusted to reflect the agency reimbursement policies for emergency room, laboratory, therapy, and pharmacy services. For state teaching, Type One, hospitals, a separate, budget neutral base rate shall be calculated. The total allowable operating rate per visit is determined by multiplying the base rate times the sum of the EAPG relative weights assigned on the hospital claim.

The statewide base rate shall be adjusted to be hospital-specific based on the geographic location of the hospital facility. The hospital-specific base rate shall be determined by adjusting the labor portion of the statewide base rate by the wage index for the hospital's geographic location and adding the non-labor portion of statewide base rate. The hospital-specific base rate for freestanding children's hospitals shall reflect a 5-

percent differential. The total allowable reimbursement per visit shall be determined by multiplying the hospital-specific base rate times the sum of the EAPG relative weights assigned to an outpatient hospital visit.

Total estimated expenditures under the new methodology should be budget neutral or the same as total estimated expenditures under the old methodology. The base rate will be recalculated at least every three years using the most recent cost and reimbursement data and current EAPG version. In non-rebasing years, rates will be updated by the inpatient hospital inflation index. The EAPG relative weights implemented will be the weights determined and published periodically by DMAS. The EAPG weights and the base rate are available on the DMAS website at www.dmas.virginia.gov. Click on Provider Services, Rate Setting Information, Outpatient Facility Rates, Outpatient Hospital EAPG. The weights will be updated at least every three years in concert with rebasing. New outpatient procedures and new relative weights shall be added as necessary between the scheduled weight and rate updates. Providers will be notified in advance of updates to the weights and base rate.

The EAPG methodology shall be transitioned over a four-year period in 25-percent increments. The transition rates for each hospital will be a blend of cost-based reimbursement and EAPG reimbursement. DMAS shall also calculate a budget neutrality adjustment every six months during the first six years of implementation.

Claim Billing Information

With the exception of laboratory claims billed on the CMS-1500, you will not have to change the claim form for billing outpatient hospital services. Claims will continue to be billed on the UB-04 claim form as currently billed. Please adjust billing practices for the following manner:

Laboratory Services

Effective for dates of service on or after January 1, 2014, laboratory services performed during an outpatient hospital visit must also be billed on the UB-04. Reference laboratory services will continue to be billed on the CMS-1500 by enrolled independent laboratory providers. Hospital laboratories performing reference laboratory services must enroll and bill as independent laboratory providers.

Revenue and Procedure Codes

Hospitals must include all diagnosis codes and applicable procedure codes and modifiers available for the services performed on each revenue line. Even if no procedure code is applicable to the revenue line, the charges for the all services are included in the base rate.

Revenue Line Item Date of Service

For each revenue line, the line item date of service must be recorded in the UB-04 form. Claims with multiple dates of services should indicate the date of service of each procedure performed on the corresponding revenue line. To be separately reimbursed for each visit, for example –therapy, dialysis, or chemotherapy services, each revenue line should include the date of service for these series-billed services.

Emergency Room Services

Effective January 1, 2014, the pend and review process for emergency room (ER) services will be eliminated. All outpatient hospital services will be reimbursed through EAPG. Hospitals will no longer be required to submit documentation of emergency services for services determined to be non-emergencies. The ER process for the Client Medical Management (CMM) Program will remain the same. CMM referrals will still be required. Any unapproved CMM non-emergency visits will be denied.

Therapy Services

Therapy services should be billed on a per visit basis. For each visit, hospitals are required to submit the following procedure code and revenue code combinations. Hospitals should not bill individual modalities.

Revenue Code	Procedure Code	Procedure Code Description
0421	97110	Therapeutic procedure (PT) **Note**: unit = a visit
0423	97150	Therapeutic procedure(s) (PT), group **Note**: unit = a group session
0424	97001	Physical therapy evaluation **Note**: unit = an evaluation
0431	97530	Therapeutic activities (OT) **Note**: unit = a visit
0433	S9129	Therapeutic procedure(s) (OT), group **Note**: unit = a group session
0434	97003	Occupational therapy evaluation **Note**: unit = an evaluation
0441	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual **Note**: unit = one treatment session
0443	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group (2 or more individuals) **Note**: unit = one treatment session
0444	92506	Evaluation of speech, language, voice, communication, and/or auditory processing **Note**: unit = an evaluation

340B Drug Discount Program

Providers participating in the 340B drug discount program must submit each drug line with modifier UD on the revenue line with the procedure code and National Drug Classification Code (NDC). All providers, including those not participating in the 340B drug discount program, must continue to submit NDC codes and units of measure for each drug submitted.

Claim Payment and Explanation of Benefits (EOB)

For each EAPG code assigned, the EAPG code and payment adjusted for payment actions determined by the 3M software will print on the corresponding revenue line of your remittance advice. The EAPG code and payment on each revenue line reflect both the 3M clinical logic and the DMAS payment policy logic. Every revenue line and procedure may not be separately payable; however, the total payment will reflect the average payment amount for all services billed. Total payment will equal the sum of the EAPG payments on each revenue line.

EDIT Information:

The following edits will be used for EAPG processing:

Edit/ESC	Description	HIPAA Codes
320	EAPG NCCI PTP	CO/B15/M80
323	EAPG NCCI MUE	OA/B5/M53
345	EAPG No Payment	CO/45/M15
351	EAPG Not Processed	CO/45/M15
359	3M EAPG Software Flag Invalid	CO/45/N620
865	EAPG Full Payment Greater than Billed Charges	CO/94/N70
1041	EAPG Consolidated for Surgical Bilateral	CO/151/M86
1042	EAPG Consolidated for Non-Surgical Bilateral	CO/151/M86
1043	EAPG Discounted for Surgical Bilateral	CO/151/M86
1044	EAPG Discounted for Non-Surgical Bilateral	CO/151/M86
1096	EAPG Packaged Procedure	CO/97/M15
1097	EAPG Packaged Per-Diem Procedure	CO/97/M15
1098	EAPG Packaged Non-Surgical Flag	CO/151/N644
1104	EAPG Bilateral - Surgical Flag	CO/151/N644
1106	EAPG Bilateral – Non-Surgical Flag	CO/151/N644
1141	EAPG Discounted Bilateral Surgical Flag	CO/151/N644
1199	EAPG Discounted Bilateral Non-Surgical Flag	CO/151/N644
1267	EAPG Same significant procedure consolidation	CO/97/M15
1268	EAPG Clinical significant procedure consolidation	CO/97/M15
1269	EAPG Multiple Significant Procedure Discounting	CO/151/M86
1315	EAPG Repeat ancillary procedure discounting	CO/151/M86
1334	EAPG Bilateral discounting	CO/151/N644
1451	EAPG Terminated procedure discounting	CO/97/N56

The table of edits reflects the edits available at implementation of EAPG for outpatient hospitals.

EAPG Example
3M Version 3.7

Assumes an EAPG Base Rate of $600.00
Primary Diagnosis: 9062 - Late eff superficial inj

Revenue Code	Procedure Code / Modifier	Final EAPG	Edit	EAPG Payment
301	80053	403- Organ or disease oriented panels		13.44
300	85025	408- Level I Hematology Tests	1096-EAPG Packaged Procedure	0.00
352	70450	299-CAT scan brain		395.46
352	70488	24- Radiologic Procedure	1268- EAPG Clinical Significant Procedure Consolidation	0.00
360	12001	12- Level 1 Skin Repair		181.80
450	99283-25	674- Contusion, open wound & other trauma to skin & subcutaneous tissue		122.58
	Total Payment			713.28

Primary Diagnosis: V4282 - Stem cell transpl status

Revenue Code	Procedure Code / Modifier	Final EAPG	Edit	EAPG Payment
0250	J2270	496- Minor pharmacotherapy		0.24
0260	96361	111- Pharmacotherapy except by extended infusion		298.98
0260	96365	111- Pharmacotherapy except by extended infusion	1267 - Same Significant Procedure Consolidation	0.00

0270	A4657	999- Unassigned	0345 - EAPG No Payment	0.00
0270	A4657	999- Unassigned	0345 - EAPG No Payment	0.00
0300	80053	403- Organ or disease oriented panels		13.44
0300	83735	400- Level I chemistry tests	1096 - EAPG Packaged Procedure	0.00
0300	85025	408- Level I hematology tests	1096 - EAPG Packaged Procedure	0.00
0300	87497	397- Level II microbiology tests		20.16
0636	J7030	496- Minor pharmacotherapy		0.24
	Total Payment			333.06

To contact 3M for more information about EAPG software, please call 800-367-2447 or use the following link: www.3MHIS.com.

Managed Care Organizations

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCOs). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may reimburse differently than as described for Medicaid or FAMIS fee-for-service individuals. For more information, please contact the MCO directly.

Reconsideration

Providers may request reconsideration of actions taken by an EAPG edit via email (HospitalEAPG@dmas.virginia.gov) or by submitting a written request with additional documentation to the following mailing address:

Payment Processing Unit, EAPG
Division of Program Operations

Department of Medical Assistance
Services 600 East Broad Street, Suite
1300

Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the EAPG adjudication for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional payment. Requests received without additional documentation or after the 30-day limit will not be considered.

Provider Appeals

If the adverse decision is upheld, the provider may appeal the reconsideration decision.

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level appeal with the DMAS Appeals Division within 30 days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals
Division

Department of Medical Assistance
Services 600 East Broad Street, 11th
Floor Richmond, VA 23219

If the provider is dissatisfied with the first-level appeal decision, the provider may file a written notice for a second-level appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia,* § 2.2-4000 et seq. The notice for a second-level appeal must be filed within 30 days of receipt of the first-level appeal decision. The notice for second-level appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals
Division

Department of Medical Assistance
Services 600 East Broad Street, 11th
Floor Richmond, VA 23219

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA), the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia, and DMAS Appeal regulations in the Virginia Administrative Code at 12 VAC 30-20-500 et. seg. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

The provider may not bill the recipient (client) for covered services that have been provided and subsequently denied by DMAS.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance

1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.